STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155388	A. BUILDING 00 B. WING	06/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORE OF BEDFORD, INC	514 EAST 16TH STREET BEDFORD, IN47421

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F0000		F0000		

This visit was for Investigation of Complaints IN00091928 and IN00091874.

Complaint IN00091928-Substantiated, Federal/State deficiency related to the allegations cited at F 225.

Complaint IN00091874-Substantiated, Federal/State deficiency related to the allegations cited at F 514.

Unrelated deficiencies are cited.

Survey Dates: June 19, 2011

Facility Number: 000370
Provider Number: 155388
AIM Number: 100290790

Survey Team: Melinda Lewis, RN , TC
Marla Potts, RN,

Census Bed Type: 29 SNF/NF
29 Total

Census Payor Type: 3 Medicare
24 Medicaid
2 Other
29 Total

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 4 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on June 22, 2011 by Bev Faulkner, RN			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure an allegation of neglect by a charge nurse leaving residents without a nurse available to	F0225	F0225- It is the policy of this facility to ensure that neglect and abandonment do not occur and that CORE Nursing and Rehabilitation provides charge nurse services at all	07/27/2011

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	provide nursing services was thoroughly investigated, in that statements were not obtained from all staff on duty and no staff member called the Administrator immediately with the allegation, for 1 of 1 allegations of neglect/abandonment. Findings include: On 6/19/11 at 1:15 P.M., LPN #1, the charge nurse, provided the current nursing schedule and indicated DoN #1 [Director of Nursing] was no longer employed by the facility and she was not sure of the name of the acting Director of Nursing. During interview with the Health Facility Administrator, on 6/19/11 at 2:00 P.M., he indicated he had received an anonymous call on 6/5/11 at home around 3 P.M. The caller told him the nurse had left the facility and grounds for approximately 45 minutes earlier that day. He indicated CNA #5 later identified herself as having made the call. He indicated he immediately phoned the facility and spoke with the nurse, who was also the Director of Nursing, DoN #1. DoN #1 told him she had not left the facility grounds but had moved her car from one parking lot to the other side of the facility to a different parking lot to have lunch with her spouse who had		times.Affected Residents:AllSystemic Changes:1) The Director of Nursing at the time of the allegation has been terminated and a new interim director of nurses has been hired.2) All staff will be inserviced regarding charge nurse duties and lunch breaks, when he/she is the only charge nurse in the building and job descriptions will be reviewed with each.3) Administration will provide in advance, a charge nurse schedule with charge nurse coverage 24 hours per day/7days per week.4) If the charge nurse is not available to complete her shift (ie:due to illness), the Administrator or designee will be notified immediately and coverage will be provided.5) Abuse and Neglect Mandatory inservice will be done now, annually and prn. (includes immediate notification of Administrator if policy has not been followed).Quality Assurance: 1) The Director of Nursing or designee will review the nursing schedules daily and make sure adequate coverage is intact daily.2) Director of Nurses will audit mandatory inservice schedule and compliance monthly.3) All employees not complying with the mandatory inservice schedule or make-up inservices will be temporarily taken off the schedule until these mandatory inservices are complete.	

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	brought her lunch. The Administrator indicated he did not go to the facility, but had started getting statements the next morning when other staff members reported the DoN had left the facility. The Administrator indicated DoN #1 had gotten some statements, one from CNA#2 but had never turned those in to him. He indicated he asked staff for statements but some on duty on 6/5/11 had not provided any. During interview with CNA # 1, on 6/19/11 at 1:40 P.M., she indicated she had worked on 6/5/11 and DoN #1 had left the facility around 12:45 P.M., for lunch and did not return until 1:30 P.M. She indicated she did not know where the DoN went. She indicated she did not report this to the facility Administrator until 8 A.M., the next day, when he asked her what had happened the day before. She stated she did not report to the Administrator because DoN #1 retaliated against staff who went against her. During interview with CNA #2 on 6/19/11 at 1:45 P.M., he indicated he was working on 6/5/11. He indicated the DoN had left the facility for lunch. He indicated he knew where she was the entire time and she had not left the facility property. He indicated she might have went to the corner gas station for soda.			

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	During interview with Activity Aide #1, on 6/19/11 at 2:15 P.M., she indicated she had worked on 6/5/11. She indicated she had observed DoN #1 leave the facility and go to her car, and then did not see her again in the facility until about 45 minutes later. Activity Aide #1 indicated she was busy with residents and might not have seen DoN #1, even if she had returned earlier. She indicated no one had asked her what she had observed that day or to provide a statement. During interview with Housekeeper #1, the Supervisor, on 6/19/11 at 2:30 P.M., she indicated Housekeeper #2 had reported to her on 6/6/11 and told her the DoN had been gone from the facility for 45 minutes on 6/5/11. Housekeeper #1 indicated she told Housekeeper #2 to go and report this to the Health Facility Administrator. During interview with Housekeeper #2, on 6/19/11 at 2:35 P.M., she indicated DoN #1 had left the facility at 12:45 P.M., and left the property in her personal vehicle. Housekeeper #2 indicated she finished clearing the dining room and took the trash out to the side parking lot where the trash container was and walked around to the back of the facility. Housekeeper #2 indicated DoN #1's			

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	vehicle was not in any parking lot. Housekeeper #2 indicated the DoN came back around 1:30 P.M., when she was standing outside. On 6/19/11 at 3:30 P.M., CNA # 2, provided written statements to the Facility Administrator he obtained from DoN #1. CNA #2 indicated he had called DoN #1 and she had brought him the statements on this date. On 6/19/11 at 3:35 P.M., DoN #1 and her spouse entered the facility. During interview, DoN #1 indicated she had never left the facility premises, but drove her car from one side of the facility to the other parking lot, which is on the opposite side of the facility to have lunch that her spouse had brought to her. She indicated she had told CNA #2 where she was going and had been on the property owned by the facility. DoN #1's spouse indicated he had brought the drinks with him. During interview with CNA #6, on 6/19/11 at 5:30 P.M., she indicated she had worked on 6/5/11, and DoN #1 had left the facility for about 45 minutes. She indicated she did not know where she was and had not looked outside for her. The Health Facility Administrator provided the statements provided by CNA			

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	#2 from DoN #1 on 6/19/11 at 4:00 P.M. The statement was signed and dated 6/8/11 by CNA#2, which included: "On June 5 th, 2011, (DoN #1 name) at approximate 1 p.m. went on her lunch break. At that time, (DoN #1) met with her husband in the lower parking lot, moving her van (automobile) to the lower lot to have a place to eat comfortably. (DON #1 name) notified this writer at approx 12:45 p.m. to her whereabouts if needed. At no point did (DON #1 name) leave the property." There was also a typed statement from DoN #1, dated 6/6/11, and included but was not limited to "The employees that made accusations regarding my where about's did not know that I was on the property, nor did they ask before making unprotected (sic) false statements about my whereabouts..." The Health Facility Administrator provided the statement he had obtained during the investigation on 6/19/11 at 4:00 P.M. A form signed by the Health Facility Administrator and DoN #1, dated 6/7/11, indicated : "On June 5 th 2011, I received a call at 3:30 p.m. The conversation went as followed (sic) 'I am an employee at Core Nursing and Rehab and I felt it to be my responsibility to notify you that the nurse left the facility for lunch.' I said is the nurse (name of DoN 1) she replied 'Yes I felt you should			

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	know.' Call placed to DoN #1 as soon as this was reported to me. Asked DoN #1 if she had left the building for lunch she stated that she had went to the lower parking lot at Core and had lunch with her husband at the picnic table. Stated that CNA #2 was aware of where she was and had seen her at picnic table. After investigation and talking with staff I found nothing that confirmed the allegation and that the call came from an employee who had turned in her 2 week notice. The employee that called in the complaint, on her last day of work 6/7, she filled out a grievance form and had another employee bring it to me after she left work today. As soon as I came to work on 6/6/11 other employees were coming to me stating DoN #1 left the property for lunch. They were not aware she went to the lower parking lot, employees have been asked to write up statements. " Written signed statements provided by the Facility Administrator, included one from CNA #1, dated 6/8/11, which indicated DoN #1 left the facility at 12:45 P.M., and was observed by CNA #1 pulling back into the parking lot at 1:15 P.M. DoN #1 had brought CNA #2 something back from Steak and Shake. A written statement, dated 6/8/11, from Housekeeper #2, included "...I was			

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	outside in the back and watched (DoN #1) drive off the property...she went out the back exit. I went inside and looked at the clock. It was 12:45 P.M. I proceed [sic] to go clean the dining room... smokers waiting...It was 1:00 P.M. I found (CNA #2 name) and he said he would take them out...at 1:10 p.m. CNA#1 and CNA #6 were there. I questioned them about the policy of the nurse on duty leaving the property with no nurse here. They told me they were not supposed to do that but were afraid to call (name of Health Facility Administrator). I then went and got my trash at about 1:20 and took it out front door to the dumpster. I walked up the hill to the back door. I saw no one in the back parking lot...It was approximately 1:30 (DoN #1) walked in the back door..." A grievance form, signed by CNA #5, dated 6/7/11, indicated DoN #1 left the facility for 45 minutes without any other nurse on duty. Written at the bottom under measure to resolve was "DoN was terminated 6/13/11, signed by the Health Facility Administrator." The Health Facility Administrator had no statements from CNA #2 until it was returned by DoN #1 on 6/19/11, nor any from Activity Aide, #1, CNA #5, or CNA #6, who were on duty. During interview			

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	on 6/19/11 at 4:00 P.M., the Administrator indicated some of the staff just did not give him statements and he did not go ask for them or interview them. He indicated no one called him at the time DoN #1 was gone from the facility. He indicated he had heard so many stories he did not know what had happened. The facility was observed on 6/19/11 at 1:00 P.M., to have two parking lots, one on each side of the facility. The parking lots were not connected. To go from one to the other by car, one would have to drive on the highway or take a back street and go around the block and on to the highway to enter the other lot. The distance from one parking lot to the other is approximately 800 feet. The policy and procedure for "Abuse", dated 12/15/03, was provided by the Facility Administrator on 6/19/11 at 5:00 P.M. The policy indicated: 'It is ...to seek to identify signs and symptoms of abuse and neglect and to report promptly any allegations of abuse and neglect to the state of Indiana...neglect-defined as failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness...This facility recognizes that abuse may include:.. neglect...abandonment...Procedure when observing alleged abuse ...report the abuse			

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	to the unit supervisor immediately and notify Administrator and DoN...investigation must start immediately...statements from all involved...information must be specific with date, time, location, who was involved and what alleged abuse is- no hear say or he said, she said...procedure for facility administrator: The facility must: ...investigate the allegations ..." This federal tag relates to Complaint IN00091928. 3.1-28(c) 3.1-28(d)			

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F0356 SS=C	The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, record review, and interview, the facility failed to ensure daily staffing was posted in a prominent place, was current and that the facility maintained the daily staffing information. The facility was unable to provide the staffing information that had been posted for 16 of 19 days for June 2011. This had	F0356	F-0356 It is the policy of this facility to ensure that daily staffing schedules are posted in a prominent place.Affected Residents: NoneSystemic Changes: 1) Daily staffing schedules will be posted by the time clock for all staff to refer to, including name of facility, census, date, shift, names and titles of	07/10/2011

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	the potential to affect all 29 residents and or their families who resided in the facility. Findings Include: On 6/19/11 at 1:00 P.M., a "Daily Nursing Assignment Sheet", dated 6/16/11, was observed on the bulletin board near the nurses station. Review of the form included the name and hours worked for "Nurse, CNA, Restorative, RN for the day." The form included the facility name, census and date. At the "Nurse" section, the form did not include the category of the nurses, whether LPN or RN's. The Health Facility Administrator provided forms for 6/9/11 and 6/13/11, on 6/19/11 at 2:00 P.M., which had been hanging behind the 6/16/11 form. He indicated at 4:00 P.M., this same day, he could not locate staffing sheets for any other day. He indicated this had been a responsibility of the past DoN and he did not know whether she had not filled them out or had not kept them. Information was available for 3 of 19 days for the month of June, 2011. 3.1-13(a)		those employees working. The night shift nurse will be responsible for making out the daily schedules.2) All previously occurring staffing schedules will be placed in a binder and located in the nursing office.Quality Assurance: The Director of Nursing or designee will make sure that all schedules are kept, for review, in a binder in the nursing office. QA will be done weekly.Date of Completion: 7/10/11	

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to document in the clinical record the elopement of Resident A, for 1 of 3 residents reviewed for elopement in a sample of 4. Resident A Findings include The clinical record for Resident A was reviewed on 6/19/11 at 1:45 P.M. The record indicated Resident A had diagnoses that included but were not limited to schizophrenia and organic brain syndrome. The MDS [minimum data set] assessment, dated 5/31/11, indicated Resident A had moderately impaired cognition. Resident A was independent with transfers and ambulation. Resident A had physically abusive behavior for 1 to 3 days during the 7 day assessment period.	F0514	F 0514 It is the policy of this facility to maintain a safe environment and a comprehensive elopement assessment on admission, quarterly with MDS review and prn.Affected Residents: Resident A was placed on 15 minute checks and a door sensor alarm was placed on her doorway to alert staff that she was out of her room.Systemic Changes: 1) Elopement assessments were reviewed on all residents.2) The Physical Therapy Departments windows were screwed shut.3) The patency of the doors will be checked daily and recorded in the Behavior Book.4) Wander Alert sheets, with identifying pictures, was initiated and placed in the Behavior Book. These Wander Alert sheets and elopement assessments will be updated quarterly and prn.Quality Assurance: 1) The Director of Nursing or designee will QA all the elopement assessments and	07/27/2011

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	155388	A. BUILDING 00 B. WING	06/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORE OF BEDFORD, INC	514 EAST 16TH STREET BEDFORD, IN47421

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	On 6/19/11 at 2:45 P.M., in an interview with the former DoN [Director of Nursing], who entered the facility during the survey, she indicated Resident A had exited the facility through a window in the therapy room. She stated Resident A had went down the ramp at the front of the building and ambulated to the alley/parking lot next to the facility before staff assisted her back inside. She stated the incident was not documented in the nurses notes because the resident was her own person and because it happened before a court appointed guardian had been named. On 6/19/11 at 3:20 P.M., in an interview with the Administrator, he indicated LPN # 2 had reported Resident A had exited the facility through the therapy room window. He indicated the DoN had then informed him the incident did not happen, Resident A was only in the secured courtyard. He stated he had spoken with the neighbor to the facility to thank him with contacting the facility concerning Resident A being in the alley/parking lot. He stated the neighbor said he did not know what he was talking about. On 6/19/11 at 3:45 P.M., in an interview with LPN # 2, she indicated she could not recall the date Resident A had gotten out		Wander Alert Sheets quarterly with MDS and with any new orders or admissions.2) An Audit of all door checks will be done daily x 2 weeks and weekly thereafter.3) The Wanderguard Alert Sheet/Book will monitored for accuracy daily x 2 weeks and then weekly thereafter by the Director of Nursing.4) Mandatory Abuse and Neglect inservicing will be done for all staff and then yearly and prn.5) Mandatory inservices will be QA'd by the Director of Nursing on a ongoing monthly basis.	

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	the window, but stated it was one of the first few days she was in the facility. LPN # 2 stated she was on duty when she received a phone call from a neighbor of the facility stating a female was at her door knocking requesting money for a cab. LPN # 2 stated she could not recall the name of the neighbor that phoned the facility. She stated the neighbor then called back to let staff know the resident was now in the alley/parking lot. LPN # 2 stated after getting Resident A back inside the facility, she contacted the former DoN and was told to start one on one with Resident A for 2 hours then begin 15 minute checks. LPN # 2 indicated she had documented the incident on a "New or Worsening Behavior Form" and placed it in a box for the DoN as she was directed to do. The completed form was not available to review, but a blank form indicated the form was to be reviewed by Social Services. LPN # 2 indicated she was not sure how Resident A got outside the facility, but the window in front of where Resident A was sitting to make a phone call was open about 6 inches. On 6/19/11 at 4:55 P.M., in an interview with CNA # 3, she indicated she had been working the evening shift when she was told Resident A had requested to make a private phone call. Resident A had been taken to the therapy room to make the			

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	call. CNA # 3 stated she had then assisted another resident to the shower. CNA # 3 indicated when she had completed the shower she was told Resident A had left the facility. On 6/19/11 at 5:00 P.M., in an interview with CNA # 4, she indicated she had been working the evening shift when Resident A left the facility. She stated she was assisting another resident, and when she was done she was told Resident A had left the facility. On 6/19/11 at 5:40 P.M., in an interview with the Social Services Director she indicated she had never seen the form. She stated she had heard talk that Resident A did exit the facility on the evening of 5/31/11, so she had implemented interventions to place Resident A on high elopement risk on 6/1/11. The Social Services Director provided the 15 minute check forms for Resident A. She stated Resident A was admitted on 5/24/11 and the facility did provide one on one supervision for the first 2 hours after admission. She stated there were no attempts of exiting seeking so Resident A was placed on 15 minute checks which continued until 5/27/11. Resident A had no attempts to exit the facility so the			

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	checks were discontinued on 5/27/11. The 15 minute check forms were started again on 5/31/11 at 8:00 P.M. The formed indicated one on one for 2 hours then start 15 minute checks. The Nurses Notes and Social Services Notes lacked any documentation of Resident A being outside the facility. This federal tag relates to Complaint IN00091874. 3.1-50(a)(1) 3.1-50(a)(2)			

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